Senate

General Assembly

File No. 157

February Session, 2016

Substitute Senate Bill No. 158

Senate, March 23, 2016

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING COST-SHARING FOR MAMMOGRAMS AND BREAST ULTRASOUNDS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-503 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(a) (1) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for mammographic examinations to any woman covered under the policy that are at least equal to the following minimum requirements: (A) A baseline mammogram for any woman who is thirty-five to thirty-nine years of age, inclusive; and (B) a mammogram every year for any woman who is forty years of age or older.

(2) Such policy shall provide additional benefits for:

(A) Comprehensive ultrasound **[**screening**]** examinations of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman's physician or advanced practice registered nurse; and

(B) Magnetic resonance imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society.

[(b) Benefits under this section shall be subject to any policy provisions that apply to other services covered by such policy, except that no such policy shall impose a copayment that exceeds a maximum of twenty dollars for an ultrasound screening under subparagraph (A) of subdivision (2) of subsection (a) of this section.**]**

(b) No such policy shall impose:

(1) A copayment or deductible for a mammogram or a comprehensive ultrasound examination under subsection (a) of this section; or

(2) Any annual or lifetime limit on the dollar value of, or number of days or visits for, a mammogram or a comprehensive ultrasound examination under subsection (a) of this section.

(c) Each mammography report provided to a patient shall include information about breast density, based on the Breast Imaging Reporting and Data System established by the American College of Radiology. Where applicable, such report shall include the following notice: "If your mammogram demonstrates that you have dense breast tissue, which could hide small abnormalities, you might benefit from supplementary screening tests, which can include a breast ultrasound **[**screening**]** examination or a breast MRI examination, or both,

depending on your individual risk factors. A report of your mammography results, which contains information about your breast density, has been sent to your physician's office and you should contact your physician if you have any questions or concerns about this report.".

Sec. 2. Section 38a-530 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(a) (1) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for mammographic examinations to any woman covered under the policy that are at least equal to the following minimum requirements: (A) A baseline mammogram for any woman who is thirty-five to thirty-nine years of age, inclusive; and (B) a mammogram every year for any woman who is forty years of age or older.

(2) Such policy shall provide additional benefits for:

(A) Comprehensive ultrasound **[**screening**]** examinations of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman's physician or advanced practice registered nurse; and

(B) Magnetic resonance imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society.

[(b) Benefits under this section shall be subject to any policy provisions that apply to other services covered by such policy, except that no such policy shall impose a copayment that exceeds a maximum

of twenty dollars for an ultrasound screening under subparagraph (A) of subdivision (2) of subsection (a) of this section.**]**

(b) No such policy shall impose:

(1) A copayment or deductible for a mammogram or a comprehensive ultrasound examination under subsection (a) of this section; or

(2) Any annual or lifetime limit on the dollar value of, or number of days or visits for, a mammogram or a comprehensive ultrasound examination under subsection (a) of this section.

(c) Each mammography report provided to a patient shall include information about breast density, based on the Breast Imaging Reporting and Data System established by the American College of Radiology. Where applicable, such report shall include the following notice: "If your mammogram demonstrates that you have dense breast tissue, which could hide small abnormalities, you might benefit from supplementary screening tests, which can include a breast ultrasound **[**screening**]** examination or a breast MRI examination, or both, depending on your individual risk factors. A report of your mammography results, which contains information about your breast density, has been sent to your physician's office and you should contact your physician if you have any questions or concerns about this report.".

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2017*	38a-503
Sec. 2	*January 1, 2017*	38a-530

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 17 $	FY 18 $
State Comptroller – Fringe Benefits (State Employee and Retiree Health Accounts)	GF&TF - Potential Cost	Less than $25,000	Less than $25,000
The State	Indeterminate - Cost	See Below	See Below

Note: GF&TF=General Fund & Transportation Fund;

Municipal Impact:

Municipalities	Effect	FY 17 $	FY 18 $
Various Municipalities	STATE MANDATE - Potential Cost	See Below	See Below

Explanation

There may be a potential cost to the state employee and retiree health plan[1] of less than $25,000 annually from eliminating copayments for breast ultrasound examinations and mammograms.[2] The potential cost is attributable to out-of-network ultrasound examinations and mammograms for members enrolled in the state

[1] The state employee and retiree health plan is a self-insured health plan. Pursuant to federal law, self-insured health plans are exempt from state health mandates. However, the state has traditionally adopted all state health mandates.

[2] The potential cost is based on an average cost of breast ultrasounds of $252 (UCONN Mandated Benefits Report, 2012) and an average cost of mammograms of $266 (Journal of Women's Health, 2011). In addition, approximately 32% of active state employees are enrolled in a POS plan and 29% of plan members are females in the appropriate age cohort for breast screening procedures covered by the bill. The estimate assumes approximately 10% of services may be subject to cost sharing.

Point of Service (POS) plans[3] and those not currently enrolled in the Health Enhancement Program (HEP).[4] The state plan does not currently impose a copayment for in-network examinations, nor does the state plan currently impose annual/lifetime coverage limits. The vast majority of members use in-network services. In addition, the bill may result in a cost to the state pursuant to the federal Affordable Care Act (ACA)(see below).

The bill's elimination of copayments and annual/lifetime limits may increase costs for certain fully insured municipalities which require member cost sharing and impose coverage limits. The coverage requirements may result in increased premium costs for the municipality when they enter into new health insurance contracts after January 1, 2017. Due to federal law, municipalities with self-insured plans are exempt from state health insurance mandates. Lastly, many municipal plans may be recognized as "grandfathered"[5] plans under the federal Affordable Care Act (ACA). It is uncertain what the effect of this mandate will have on the grandfathered status of those municipal plans.

The State and the federal ACA

Lastly, the ACA requires that, the state's health exchange's qualified health plans (QHPs)[6], include a federally defined essential health benefits package (EHB). The federal government is allowing states to choose a benchmark plan[7] to serve as the EHB until 2016 when the federal government is anticipated to revisit the EHB.

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[3] Members enrolled in a POS plan are required to pay 20% of allowable costs after satisfying the plan deductible and 100% of costs charged by the provider in excess of the allowable cost.

[4] Members not enrolled in the HEP plan must satisfy the plan's deductible for services where there is no cost sharing.

[5] Grandfathered plans include most group health insurance plans and some individual plans created or purchased on or before March 23, 2010.

[6] The state's health exchange, Access Health CT, opened its marketplace for Connecticut residents to purchase QHPs from carriers, with coverage starting January 1, 2014.

[7] The state's benchmark plan is the Connecticare HMO plan with supplemental coverage for pediatric dental and vision care as required by the ACA.

While states are allowed to mandate benefits in excess of the EHB, the federal law requires the state to defray the cost of any such additional mandated benefits for all plans sold in the exchange, by reimbursing the carrier or the insured for the excess coverage. Absent further federal guidance, state mandated benefits enacted after December 31, 2011 cannot be considered part of the EHB unless they are already part of the benchmark plan.[8] However, neither the agency nor the mechanism for the state to pay these costs has been established.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future based on the utilization of out-of-network services by members.

Source *Office of the State Comptroller State Health Plan, Plan Benefit Document as of January 2015.*

[8] *Source*: Dept. of Health and Human Services. *Frequently Asked Questions on Essential Health Benefits Bulletin* (February 21, 2012).

OLR Bill Analysis

sSB 158

AN ACT CONCERNING COST-SHARING FOR MAMMOGRAMS AND BREAST ULTRASOUNDS.

SUMMARY:

This bill prohibits certain health insurance policies from charging copays or imposing deductibles for mammograms and comprehensive breast ultrasound exams. Under the federal Affordable Care Act ("ACA," see BACKGROUND), most health insurance policies cannot impose copays or deductibles for mammograms conducted in accordance with national guidelines (e.g., annually as appropriate for older adults). Current state law requires these policies to cover ultrasounds for women when a mammogram reveals dense breast tissue or she is at an increased risk for breast cancer, but allows the policies to impose up to a $20 copay.

The bill also prohibits health insurance policies from placing annual or lifetime dollar or visitation limits on mammograms and comprehensive breast ultrasounds. These limits are the maximum amount or number of visits, respectively, a policy covers in a given timeframe for a specific service. The ACA prohibits many health insurance policies from imposing such limits for mammograms.

The bill also specifies that these policies cover ultrasound exams, instead of screenings, and makes conforming changes.

The bill applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. It also applies to individual limited benefit health insurance policies. Because of the

federal Employee Retirement Income Security Act, state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2017

BACKGROUND

Related Federal Law

Under the federal Patient Protection and Affordable Care Act (P.L. 111-148), certain preventive care services, including mammograms, must be provided without copays, deductibles, or lifetime or annual dollar limits.

The ACA allows states to require health plans sold through the state's health insurance exchange to offer benefits beyond those included in the required essential health benefits, provided the state defrays the cost of those additional benefits. The requirement applies to state benefit mandates enacted after December 31, 2011. Thus, the state must pay the insurance carrier or enrollee to defray the cost of any new benefits it mandates after that date.

Related Bill

sHB 5233, favorably reported by the Insurance and Real Estate Committee, requires the same health insurance policies to cover tomosynthesis. Tomosynthesis is a three-dimensional mammography method.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 15 Nay 3 (03/11/2016)